STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011772	A. BUILDING: _____ B. WING _____	07/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEART HOSPITAL AT DEACONESS GATEWAY LI	4007 GATEWAY BLVD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was a State investigation of 1 hospital complaint. Complaint: #IN00142621 Unsubstantiated - Lack of sufficient evidence Survey Date: 7/29/14 Facility #: 011772 Surveyor: Trisha Goodwin, R.N. Public Health Nurse Surveyor The Heart Hospital at Deaconess Gateway is in compliance with 410 IAC 15-1.4-2, Quality assessment and improvement, 410 IAC 15-1.5-4, Medical record services and 410 IAC 15-1.6.4, Outpatient services, Indiana Hospital Licensure Rules. QA: claughlin 08/08/14	S 000		